– Not Government Policy –

Queensland Mental Health Commission

Consultation paper:

Development of a whole-of-government Trauma Strategy for Queensland

Trauma in an Older Adult Context.

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What is this research about

This research examines trauma within the context of an older adult population. The purpose is to understand the prevalence and characteristics of trauma within this population, as well as to consider the relevant implications for policy makers, including contributing to a whole-of-government trauma strategy.

The context for this research

The Australian Institute of Health and Welfare[1] defines trauma as "Any event that involves exposure to actual or threatened death, severe injury, or sexual violence …. The trauma experienced can be physical and/or mental and not everyone will respond in the same way."

According to AIHW estimates[1], 75% of Australian adults have experienced trauma at some point in their life. Unfortunately, the data is lacking in general within Australia in terms of trauma and post-traumatic stress disorder (PTSD) in older adults. However, the rate of 75% across adults aligns with other work around the world, which offers prevalence rates of between 20-90% depending on how trauma is defined and the country under study[2,3]. A rate of approximately 55% of older adults having experienced some form of trauma, within a German community sample, has also been reported[3]. In terms of PTSD, United States data suggests a prevalence rate of approximately 2.6% (current) and 4.5% (lifetime)[2], a rate similarly found in other studies[3,4]. Research also indicates that the prevalence rates of PTSD in older adults is lower than that in younger adults, with older adults also reporting lower levels of distress and fewer PTSD symptoms[5,6]. Of course, prevalence of trauma is a different topic compared to a diagnosis of PTSD and here, beyond the AIHW estimate mentioned earlier, there is more to be done to better understand prevalence rates of trauma (outside of a PTSD diagnosis) within the older adult population. Nonetheless, the evidence is clear regarding the impact of trauma on older adults, including the potential for ongoing effects well beyond the time the trauma was experienced, which will be explored next.

The key findings

Trauma can take many and varied forms, as can the reactions of individuals who experience trauma. It is readily acknowledged that while a number of people can experience the same traumatic event, there is the potential for that group to include those who experience no lingering reaction through to those who experience lifelong dysfunction as a result of the same trauma experience. Such variation is readily captured in the literature with a review of the mental health of older adults post-natural disaster finding that older adults were more than twice as likely to develop PTSD compared to younger adults[7]. On the other hand, Australian researchers have identified that while older adults experienced similar levels of distress during a trauma inducing event, they had more effectively reduced their experience of distress within a week compared to younger adults[8]. And so, age differences in terms of coping with trauma are also apparent, as well as other individual differences[9]. Further highlighted has been the potential for ongoing mental health issues in older adults, across their lifetime, who have experienced PTSD[3], as

well as increased risk of dementia in those diagnosed with PTSD[10]. Relatedly, a meta-analysis identified that those older adults who had been diagnosed with PTSD performed less well than expected in cognitive testing, particularly in relation to memory and learning[11]. Within an older adult population, the experiences associated with getting older such as the losses commonly associated with retirement and death of loved ones and friends may exacerbate the psychosocial effects of trauma[12].

The literature also indicates that adverse childhood events (ACEs), including trauma-related events, can play a role in the mental well-being and quality of life of older adults who have experienced said events earlier in their lives[13]. This again highlights the long-term, lingering effects of trauma, and potentially across decades in fact. Wilson-Genderson and colleagues, for example, explored the influence of ACEs on coping with subsequent trauma experiences, such as natural disasters (i.e, Hurricane Sandy), identifying that an individual who has experienced ACEs is more vulnerable to the negative impact of trauma, including depression (rather than having developed resources that might make them less vulnerable)[14]. Similarly, and within a Korean older adult population, those who had experienced traumatic events during their lifetime were at greater risk of experiencing psychiatric disorders, as well as poorer mental health (including increased risk of depression)[15], and reduced life satisfaction more generally[16,17]. Further, it has also been identified that ACEs have the potential to impact on poverty levels in older adults within a Chinese population[16]. Cameron and colleagues further highlighted the lingering impact of trauma in their study exploring unresolved trauma in residential aged care, emphasising once again the long-term emotional impact that trauma can have[18]. Indeed, other researchers have highlighted the risk of assuming that because the experience of trauma occurred many years previous that it should no longer be seen as impacting the life of the older adult[19]. Such assumptions can mean that the mental health needs of the older adult are minimised and potentially treated inappropriately for their context given there is a risk that their experience of trauma many years ago could be minimised as a contributing factor in current functioning concerns[20].

In a similar vein, the literature – while quite limited – also highlights the considerable impact on older adults of elder abuse[21,22]. Such experiences are commonly traumatic and stressful and can remain undetected due to the very nature of an abusive relationship (e.g., coercive power). The older adult being taken advantage of may also experience reduced capacity in terms of understanding, and therefore having a voice, in what is happening to them. In Queensland, 67% of reports to the Elder Abuse Prevention Unit Hotline noted more than one type of abuse occurring, with 63% of reported victims living with the perpetrator(s) and in almost all cases, the perpetrator was a family member[22]. Such characteristics mean that exposure to the trauma is ongoing and often unavoidable without significant external support and input, placing the older adult at even greater risk of negative outcomes[21,22].

Environmental factors can also play a role in the ability to cope with trauma. For example, settings such as residential aged care facilities may, inadvertently, be a triggering experience[12] particularly for those who have previously experienced trauma related to institutionalised settings[23]. In addition, those living with dementia who are transitioned to aged care may be at risk of re-experiencing past trauma. For example, those with a history of sexual abuse can find the need to be showered and toileted by a staff member very distressing. Further, trauma experiences that had previously been managed through such strategies as repression, avoidance, or positive reframing, can come to the fore in circumstances where the brain itself can no longer engage in using such coping strategies[23,24]. Such re-traumatising events can result in behaviours such as aggression and agitation, which are essentially the outward expression of the internal state of distress. And while these behaviours can be upsetting

and confronting to those around the person living with dementia, they are in fact an expression of psychological distress that requires appropriate treatment and support. Most concerning is that in residential aged care, access to psychological support is very limited to the point where in most facilities, no such support is available[18]. This means that while the literature indicates that the risk of experiencing mental health issues, including those as a result of trauma, are high in residential aged care, there is little appropriate support for those living in aged care. Community living situations can also impact on the ability to cope with trauma. It has similarly been identified that older adults living in areas prone to cyclones (and therefore potentially trauma inducing situations) are often required to be self-reliant in such situations but are of course also not sure what the future might bring (and therefore whether they would cope)[25]. This is counterbalanced of sorts with the notion of people wanting to choose to live where they want to, regardless of the potential risks. And, in some instances, the choice to live elsewhere is not necessarily an option for a range of reasons. It has therefore been proposed that, while it might be a reasonable government and council policy to encourage self-reliance in disaster prone areas, there is a related need to build social capital in these same areas to ensure that all members of the population (regardless of capability) are able to cope and be appropriately supported when disaster occurs[26].

Intergenerational trauma is a term used to describe the trauma experienced by offspring of those who have experienced a trauma event. Rather than personally experiencing the said trauma, the trauma experience is transferred from those who experienced it to their children, grandchildren, and so on. Examples include the Stolen Generation, Holocaust survivors, and 9/11. Importantly, research indicates that not only can the negative impact of such shared trauma be experienced by future generations, but also resilience, strength, and positive growth[27]. What intergenerational trauma more importantly highlights within an older adult context is that the older adult themselves may have experienced trauma and/or they may have experienced trauma vicariously through their own parents and grandparents. Relatedly, migrants can be at greater risk of poor mental health outcomes in the host country, particularly refugees, who are considerably more likely to have experienced trauma and yet because of their citizenship status are often not able to access appropriate services[28]. Generally speaking, older adult refugees tend to be underrepresented in general and services are not typically geared to best support this age group in a refugee context. This leaves this portion of the population at increased risk of poor outcomes, reduced access to support, and increased morbidity and mortality rates[29].

What does this research mean for policymakers

The literature demonstrates that both adverse childhood experiences and adverse adult experiences contribute to the way in which individuals cope in older adulthood (both generally and in response to further trauma-related experiences). Similarly, the psychological and physiological challenges of the individual (current and past), as well as trauma history, also play a role in coping ability[30].

Where feasible, policymakers should consider in what ways policy can both reduce the risk of traumatising situations occurring and remove (or at least reduce) the risk of re-traumatising individuals. Trauma-informed approaches essentially build upon the premise that anyone coming into contact with a particular service or organisation may have been exposed to a traumatic event at some point in their lifetime. Such approaches also remove the need to have a full appreciation of who the trauma impacted individuals are that are engaging with any particular service (i.e., one does not necessarily need to know who has or who has not experienced trauma and the impact of said trauma(s) on that individual to ensure everyone feels safe within a particular context). Therefore, an overarching philosophy or goal of attempting to avoid re-traumatising individuals by encouraging supportive,

nurturing, and safe environments (including respect for diversity and inclusion), as well as allowing for autonomy, choice, collaboration, and empowerment would play a key role in any whole-of-government trauma strategy[19,31,32].

Most importantly, while there are key principles that can be drawn upon in support of developing a whole-of-government trauma strategy, the research and lived experience of those who have experienced trauma also makes it clear that there is heterogeneity. The needs of the individual must therefore also be considered as part of the package, given a one-size-fits all approach without flexibility would actually have the potential to cause more harm. Instead, reliance on trauma-informed approaches, with person-centred principles built in, would go a long way to ensuring the provision of support needed in a way that would avoid traumatising (or re-traumatising) consumers. Such an approach would also readily meet the needs of the individual, and therefore offer the best opportunity to cater to the needs of the older adult population (particularly those who have experienced, and continue to be impacted by, trauma).

Options for reform

Fundamentally, while sparce in relation to older adults in particular, the literature points to the value of prevention as a means of 'preparing' people to be able to better cope with traumatic experiences, as well as providing training in trauma-informed approaches to ensure that those who have experienced trauma and engage with organisations and within other contexts are not further (and often inadvertently) traumatised.

Prevention strategies:

Reducing or removing the potential for trauma inducing events to occur (including re-traumatising events) would be an ideal prevention strategy, while also acknowledging that trauma is, for better or worse, a part of the lived experience. Therefore, the next most significant contribution to prevention would be to build resilience and mental well-being strategies (e.g., through community-based programs) to better prepare individuals for coping with trauma-based experiences. It would also be beneficial to include emotion regulation, meaning making, and post-traumatic growth strategies given such abilities are commonly reported as assisting with the recovery from trauma[33,34]. Relatedly, it has been identified that not only giving social support but also receiving social support, are factors that can play a role in better outcomes post-trauma[35].

Reducing the risk of adverse childhood events (ACEs), which while challenging, would assist in reducing vulnerabilities in terms of risk of ongoing mental health concerns. The literature is clear that where such events have been experienced, there is a higher likelihood of adverse outcomes when experiencing further traumatic events, as well as a cumulative effect of such incidents, which places older adults at greater risk of adverse outcomes overall. Attempts at reducing ACEs would mean, for example, reducing the risk of childhood abuse and neglect, creating and promoting safe school environments, addressing stressors that commonly result in domestic violence situations, and better preparing communities to support young people in disaster contexts (see 'Trauma in Young People' policy evidence summary). Similarly, reducing the risk of elder abuse (including effective strategies in identifying and intervening) would minimise the trauma commonly associated with such experiences (and further avoid the cumulative effect of trauma on the life of older adults).

Fundamentally, more research focused on older adult populations and their experience of trauma would allow for exploration of further ways in which individuals might learn to cope better with trauma. This would be particularly important in instances where an older adult's first experience of trauma is as an older adult and hence, they may

not have had the opportunity to build up skills across their lifetime to cope with such adverse events. This is an area particularly lacking in the research, but more research as to how to best work with and treat older adults who have experienced trauma at any point in their lifetime would further benefit from more robust research. Those living with dementia are particularly neglected in trauma research and yet they are often some of our most vulnerable who more often require external supports to assist them in coping with their trauma experience(s).

Finally, prevention often relies on a change in culture and associated with this, a building up of awareness and understanding (that can in fact be stymied within organisational or community cultures that do not appreciate the real impact of trauma). While most in any given population would recognise that in general, trauma is more commonly a negative experience, building awareness as to the coping strategies that can cause people to be more vulnerable to negative outcomes can play a key role in ensuring better outcomes. Similarly, it is important to acknowledge and understand that people can indeed react differently to instances of trauma, and this would assist in ensuring that cultures (e.g., within an organisation, a community, a state, etc…) would be more aware of the various roles trauma can play in life and prevent the application of a one-size-fits-all, stereotyped, and/or invalidating response/intervention.

Trauma-Informed Approaches:

By far the most supported and encouraged means of ensuring those who have experienced trauma are not traumatised further is the instigation of trauma-informed approaches within various contexts such as workplaces, government services, prisons, schools, residential aged care, etc…. The Substance Abuse and Mental Health Services Administration highlight four factors underpinning the philosophy behind trauma-informed approaches: (a) realise that trauma has widespread impacts and that there are pathways to resilience and recovery for individuals with trauma histories, (b) recognise the signs of trauma in people, (c) respond by integrating knowledge about trauma into their practices, and (d) actively resist re-traumatising people[36].

SAMHSA[36] also highlights the core principles of trauma-informed approaches, including: the promotion of safety; trustworthiness and transparency; peer support; authentic collaboration; empowerment; and humility and responsiveness. Such principles benefit not only consumers, but also staff, ensuring increased engagement with services, trusting relationships, reduced risk of burnout, and therefore allowing for better (and longer term) outcomes across a range of contexts[12,37]. Importantly, and more broadly speaking, when one factors in that an older adult's previous experience with an organisation(s) may have been traumatising in and of itself, ensuring a trauma-informed approach would ensure that the individual would feel safe seeking the services and support that they need. The follow-on effects of this being that they would have improved mental wellbeing and quality of life. Unfortunately, training in trauma-informed approaches is limited, and research utilising the approach across a range of settings catering to older adult populations even more so. Nonetheless, the research that is available supports the mitigating effects of trauma-informed approaches[12,38]. Reform would therefore readily come from upskilling staff, across various settings and contexts, in the principles of trauma-informed approaches.

Trauma-informed approaches typically rely on training staff in the principles of the approach[37,38], paying particular attention to ensuring relevance to the particular context so that staff have ready on-the-ground examples to learn from and model. For example, a hospital ward would be a different context to a government support service. Research also highlights the utility of so-called champions within the staff population[37]; those members of the team who can be sought out for advice, highlight instances where trauma-informed practice could be improved, etc….

While the trauma landscape is complex, there is clear evidence of the impact of both historical and recent trauma events on our older adult population. Engaging in best practice principles (i.e., trauma-informed approaches) at a government (including health and aged care) and community level would go a long way to ensuring higher levels of mental health and wellbeing and create environments in which our older Australians would feel safe to seek out the support that they need to live better lives[23,37].

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